Hospital Liability for Suicide: A Regional Survey

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Introduction

When a hospital is sued following a patient suicide, the usual claim is wrongful death. An earlier study1 and more recent claims data2,3 show it to be a frequent basis for negligence actions against psychiatrists and psychiatric hospitals. The notion that patient suicide in a hospital setting is, of itself, evidence of poor or inadequate professional care has an obvious common-sense appeal. However, it has been well argued4 that not all suicides can be prevented and that effective treatment usually involves taking calculated risks. The clinical alternative, a more traditional and conservative approach, which in some cases may amount to little more than custodial care, may not be in the patient’s best interest. Such an approach can promote and maintain an extravagant dependency and thwart treatment efforts which encourage maturation and individuation.

The psychiatric hospital is probably the most common setting in which severely depressed patients are treated. Suicidal behavior forms the basis for a substantial number of hospital admissions, with the expectation that the psychiatric ward is a relatively safe setting in which to commence evaluation or treatment. In most cases this is probably so. However, hospitalized patients do kill themselves, and the effect on other patients and the ward staff can be shattering. We have discussed this aspect of patient suicide in another paper5 and wish now to extend our assessment in a direction to include the hospital itself as a public service and business entity.

At a time when medical malpractice has become a national issue, there is no doubt that psychiatric hospitals will be held more strictly accountable for the quality of care they provide. Our recent review of court actions subsequent to hospital suicide6 showed a distinct trend toward greater liability for both hospitals and doctors. While such a judicial posture may sometimes seem unwarranted, and can run counter to enlightened efforts at treatment, it has in fact become a reality.

Hospital Survey

In our original study7 we wanted to learn how often patients in Los Angeles psychiatric hospitals committed suicide. Because suicide is a

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sensitive area for both hospitals and clinicians, we devised a form of inquiry and follow-up based on personal contact with the responsible staff of all facilities located in the area under study. Of 33 hospitals surveyed, 27 responded. This gave a return rate of better than 80%. Since the design of the survey provided for an anonymous reply, it was not possible to identify those institutions which failed to respond. Each of the 33 hospitals contacted met the requirements of being located in Los Angeles County and having a psychiatric inpatient service in operation for at least one year. The major thrust of the inquiry was directed toward determining the incidence of completed suicide the hospital had experienced during the preceding five years and obtaining certain factual data concerning each event. We also asked for specific clinical information on each patient.

The final portion of the questionnaire inquired about subsequent litigation, the filing of a law suit against the hospital, settlement, amount of settlement, and whether or not the matter was tried in court. These data are the subject of this report.

Survey Results

Of the 27 responding hospitals, six were involved in litigation following a patient suicide. One hospital had three such cases; two other hospitals had two cases, and the remaining three hospitals each had one case. Of these 10 cases, nine resulted in law suits being brought against the hospital and/or staff. One case was apparently settled for less than $10,000, possibly prior to a suit being filed. Of the nine cases which involved law suits, five were settled prior to going to trial. In each case settlement exceeded $10,000 but was less than $100,000. Two of the four cases which were not settled are awaiting trial and the others are in some stage of preparation. One was described as still being in the discovery phase.

The patient group productive of litigation showed few special characteristics when contrasted with the total group of hospital suicides. The mean age was 39 years, with a range of 26 to 56 years. Of the 10 cases, seven were men and three were women. This gives an average age and a sex ratio almost identical to that found in the total group. Eight patients were married, one was divorced and one was single.

Depression was the most common diagnosis and was assigned to seven of the 10 litigated cases of hospital suicides. Psychotic and neurotic forms of depression were equally represented. Only two patients were diagnosed as schizophrenic. The other patient, diagnosed as a hysterical personality, was probably also depressed. Seven of the 10 were in the hospital at the time of their suicide. Five were on locked wards and three were on special or suicidal observation. The three patients not in the hospital were on unauthorized absence from their wards.

The methods of suicide were generally similar to those encountered in the total group of hospital suicides. Four involved hanging. One patient strangled himself with a wire coat hanger; one used a plastic bag over the head. Another stabbed himself and one jumped from a building. Two patients ran off and threw themselves before on-coming vehicles. This last mode and the stabbing were unique to the litigation group.
The hospital staff respondents judged that in five of the ten litigated cases there was definite or strongly suggestive evidence of preventability. Four cases were considered equivocal, and only one was rated as showing no such evidence. (It is somewhat disconcerting to note that this patient was on a locked ward and managed to hang himself with a belt.)

The respondents indicated that an exhaustive investigation was made in seven of the 10 litigated suicides and a thorough investigation was made in the remaining three. This is in contrast to the total group of hospital suicides, in which one-third of the cases were reported as having initiated cursory or no investigation.

Of the six institutions involved in litigation, four had fewer than 50 beds; the remaining two had between 50 and 200 beds. No large hospital, i.e., over 200 beds, reported the filing of a law suit. The six hospitals were equally divided between public and private sponsorship. No V.A. facilities were involved in litigation, although they contributed almost 30% of the total group of hospital suicides.

**Discussion**

Our hospital survey covered all inpatient psychiatric facilities in Los Angeles County and achieved a return rate in excess of 80%. During the preceding five years these hospitals experienced a total of 49 suicides, of which we have case reports on 45. This finding suggests that the actual number of hospital suicides is not large. It does not mean that the hospital treatment of suicidal patients is without risk. While even one suicide is a tragedy for all concerned, a rate of less than 10 per year over a five-year period, when drawn from a metropolitan community of more than seven million people, may indicate that our hospitals are doing a very good job of controlling self-destructive behavior. Since a suicidal gesture or attempt is a common justification for admission to inpatient status, there can be little doubt that the responding hospitals had substantial exposure to depressed and potentially suicidal patients. Much of the clinical satisfaction we might derive from this inference, however, can be readily offset by our additional findings.

In almost one-quarter of the 45 reported cases some form of legal action was initiated following the suicide. What this means cannot be stated with certainty. However, further consideration of our survey data may offer some explanation. The inception of legal action in such circumstances usually indicates retrospective dissatisfaction on the part of family and relatives with the quality of service provided. While in many cases highly personal and perhaps even irrational motives may be operative, the usual basis for claims is faulty care or professional negligence.

A comparison of the 10 litigated cases with the 35 which were not litigated shows interesting differences. All litigated cases were the subject of either an exhaustive or a thorough investigation. In contrast, almost one-half of the non-litigated cases received cursory or no investigation. This discrepancy could be explained by assuming that, in the eventually litigated cases, immediately after the suicide there was some hint of possible legal action and thus greater incentive fully to clarify the clinical circumstances.

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One might also reason that those hospitals which did a thorough investigation were seen as "better" facilities by the family and thus held by them to greater accountability.

Retrospective estimates of preventability were higher in the litigation group. While only four of 30 non-litigated and rated cases (5 did not report estimates) showed definite or strong evidence of preventability, 5 of the 10 litigated cases were so rated. Although this might be explained on the basis of certain of the more obvious forms of hospital negligence, a review of the clinical accounts does not set these cases apart. Rather, it may again reflect a higher level of clinical expectation from what is, in fact, a more discriminate and self-critical institution.

Certain patient categories were not seen in the litigation group. There were no V.A. patients, no elderly patients, and no patients who were on authorized leave. All three categories were well represented in the non-litigation group.

Six of the 10 litigated cases were settled without going to trial. While most conscientious clinicians are inclined to regard settlement as an unpalatable alternative which they might prefer to avoid, the fact that the majority of cases were settled and none have gone to trial would surprise no one familiar with the professional liability insurance industry. The factors involved are mostly economic. Malpractice cases involving suicide do not try well before a jury. Jurors are inclined to identify with the bereaved family and tend to put logic aside in an effort to compensate for suffering and grief. The hospital and its staff may be seen as an impersonal entity and the sole available resource with which to right what appears to be an obvious clinical wrong. Settlement avoids the cost of a trial and fixes the loss. But it does so at the risk of encouraging future actions of perhaps dubious merit wherein the issue of quality of care is subordinated to familial outrage.

The dollar cost of the six settled cases was not large. If we assume a mean settlement of $50,000 per case, a not unreasonable figure, the total is $300,000, which is very modest in the current market. While it must be recognized that legal and claims administrative expenses would be added to this amount, the total would probably not exceed $500,000 and the value of all claims, including the four still in litigation, might well total less than a million dollars. Over a five-year period this amounts to a total of $200,000 per year for 27 hospitals at risk.

There will always be great difficulty in predicting infrequent occurrences, and we have shown hospital suicide to be just such an event. Measures calculated to protect the few not only can fail in their intent, but also may serve to deprive others of more adequate treatment. Our findings suggest that program changes stressing greater vigilance over depressed and possibly suicidal patients are most unlikely to be a significant factor in altering ultimate hospital liability for suicide. The projected claims value of suicide liability appears modest and would not offer economic justification for program restriction undertaken to reduce such risk.

References

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